

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **2371**

FEB 25 1941

Registration District No. **31**

Primary Registration District No. **5315**

Registrar's No. _____

1. PLACE OF DEATH:

(a) County **Crawford**
(b) City or town **Boonville**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____
In this community **50 years** (Specify whether years, months or days)

3. (a) PRINT FULL NAME **Samuel Robert Darst**

3. (b) If veteran, name war _____ 3. (c) Social Security No. _____

4. Sex **M** 5. Color or race **W** 6. (a) Single, widowed, married, divorced **2**

6. (b) Name of husband or wife **Americe Darst** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **3** **3** **1884**
(Month) (Day) (Year)

8. AGE: Years **86** Months **10** Days **4** If less than one day hr. _____ min. _____

9. Birthplace **Ohio** (City, town, or county) (State or foreign country)

10. Usual occupation _____

11. Industry or business _____

12. Name **Charley Darst**

13. Birthplace **Ohio** (City, town, or county) (State or foreign country)

14. Maiden name **Hackman**

15. Birthplace **Ohio** (City, town, or county) (State or foreign country)

16. (a) Informant **Wm Darst**

(b) Address **Steelville Mo**

17. (a) _____ (b) Date thereof **2-2-1941**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Verona Mines**

18. (a) Signature of funeral director **L. J. Jones**

(b) Address **Steelville Mo**

19. (a) **2-19-41** (b) **C. H. Hibbs**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Mo** (b) County **Crawford**
(c) City or town **Rural** (If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location) **0**
(e) If foreign born, how long in U. S. A. _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **1** day **30**
year **1941** hour **10** minute **10 A.M.**

21. I hereby certify that I attended the deceased from **Jan 1**
19**41**, to **Jan 30** 19**41**;
that I last saw him alive on **Jan 25** 19**41**;
and that death occurred on the date and hour stated above.

Immediate cause of death **Ischemic heart disease**

Due to _____

Due to **376**

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings: _____

Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____ (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? **20**

While at work? **Yes** (Specify type of place) (e) Means of injury _____

23. Signature **R. B. Jones** (M. D. or other) **D**

Address **Steelville Mo** Date signed **2-30-41**

RECEIVED

District Health Officer No. 5

District File Number 241304

Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Registered Apprentice No. _____, working under my personal supervision.

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.